



WORLD RELIEF CAMBODIA
“ LIGHT FOR LIFE”
COST EXTENSION CHILD SURVIVAL PROGRAM
FIRST ANNUAL REPORT



Authors: Oun Sivan, Light for Life CE CSP Director
Geoffrey Bowman, RN, WR Cambodia Health Advisor
Melanie Morrow, MPH, Child Survival Specialist
Kathryn Norgang, BA, Program Assistant

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Kampong Cham Province, Cambodia

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First Year Highlights: Response to Dengue Fever Outbreak

Due in part to unusual amounts of rain during July and August of 2003, an outbreak of dengue fever increased morbidity within 21 villages of the project area. Project volunteers reported additional deaths and infections resulting from misinformation related to treatment for dengue fever, as many families sought harmful treatments from traditional healer “injectionists”. World Relief staff responded quickly to data collected by project volunteers from the affected communities. They modified current intervention lessons to incorporate preventative and care seeking messages specific to dengue fever, while at the same time maintaining scheduled project activities according to the work plan. Villages with a high number of fever cases were specifically targeted.

The project staff accompanied volunteers on home visits to monitor homecare treatment and emphasize referrals to health facilities. Care Groups were responsible for following up with each family and for spreading awareness in their individual villages. The Behavior Change Communication Drama Teams reinforced the volunteers’ work and were particularly successful in communicating with village leaders.

As a result, the number of deaths due to dengue fever stabilized in the project area. At a recent Provincial Coordination Committee meeting, the project staff shared lessons learned in responding to the recent outbreak, and used their experience to advocate for greater access to health facilities in rural districts, and to encourage scaling up community reporting/mobilization strategies in event of any public health crisis. This experience was crucial not only to curbing the outbreak and saving lives, but also in further demonstrating to communities, especially in the expanded project area, their ability to take action for health.

ACRONYMS

BCC	Behavior Change Communication
CDD	Control of Diarrheal Disease
CGL	Care Group Leader
C-HIS	Community Health Information System
CE CSP	Cost Extension Child Survival Project
CSP	Child Survival Project
EPI	Expanded Program for Immunization
HC	Health Center
IMCI	Integrated Management of Childhood Illness
KPC	Knowledge Practice and Coverage
LRA	Local Rapid Assessment
MOH	Ministry of Health
HFS	Heath Field Staff
PVO	Private Voluntary Organization
VDC	Village Development Committee
VL	Village Leader
WHE	Women Health Educator (volunteer)
WR	World Relief

PROGRAM LOCATION

The Light for Life Cost Extension Child Survival Project (CE CSP) is a collaborative partnership between World Relief (WR) Corporation/USAID, the Ministry of Health (MOH) of Cambodia, and the communities of Ponhea Kriek/Dambai District in Kompong Cham Province. The project is located about 5 hours drive north east of Phnom Penh, on the Ho Chi Minh trail, close to the border of Vietnam. The beneficiary population includes 46,128 women of reproductive age (15-49 years) and 20,344 children under five years. The total population for the operational district is 184,642.

The CE CSP seeks to improve the health status of the women and children through families making timely and appropriate health choices based on sound knowledge and to strengthen the capacity of the health system.

A. MAIN ACCOMPLISHMENTS:

The primary, overarching accomplishment made in this first year of operation has been strengthening community development capacity within the extended project area. Building upon success from the first Child Survival Project (CSP), the WR Health Field Staff (HFS) continues to strengthen communities and the health system through a bottom up approach. By promoting strong and effective volunteer Women Health Educators (WHEs) from the first project to become leaders and mentors for new WHEs in the expanded project area, the CE CSP is furthering community capability and leadership structures. Making these experienced WHE supervisors in the new area has been a successful mechanism for transferring skills between community members and has enabled the CE CSP staff to quickly bring the new care groups to a high level of functioning. WHE supervisors will also strengthen sustainability post project. Additional accomplishments are summarized below.

1. Staff Recruitment and Systems Development

The CE CSP covers a population and geographical area more twice the size of the original project. Orienting new staff quickly and transferring increased responsibility to communities has been a significant achievement during this first year of operation. In October 2002 the project recruited and trained 2 new HFS and 5 Behavior Change Communication (BCC) promoters. In addition to training in intervention skills and participatory adult education techniques, all project staff received further training in stress management, child development, interviewing, and conducting focus group discussions.

During 2002-2003, the WR HFS have matured in their role as “trainers of trainers,” focusing on effective management and mentoring of the WHE volunteers. Successful training and capacity building in the community is key to reaching the ambitious project scope, and more importantly, to a method of project implementation that builds sustainable community development structures and long term behavior change.

Currently there are 4 HFS working in the old area, compared to 16 in the original project, so each HFS now covers an area 4 times larger than before. Each HFS in the new area mentors 16-17 care groups. The HFS visit each care group they are responsible for once each month (See Annex A for

Organizational Chart, and Annex B for Field Responsibility Structure & Community Responsibility Structure).

During care group meetings the HFS teach a new health message, help the WHEs practice teaching the lessons so they will be prepared when they do home visits, and discuss any current problems or concerns of the care groups. The HFS also collect vital statistics that the WHEs report from the households they are responsible for, such as births, deaths and illnesses. These data make up the Community Health Information System (C-HIS), which the project uses to track progress, detect problems, inform district health officials and report back to communities.

The BCC promoters use drama, song, puppetry and mime, to teach not just mothers but also children, men and community leaders about healthy behavior in a fun, entertaining atmosphere. BCC teams reinforce the key family practice lessons taught in households by the WHEs, and also support MOH outreach activities by drawing mothers and children to the immunization sessions. Teams of two BCC promoters are responsible for 70-75 villages.

In January 2003, 49 strong Care Group Leaders in the old area were selected to be WHE supervisors and work part time in the new area for 5 days each month. All WHE supervisors were trained and are mentored by the HFS. Each one is now responsible for 4 care groups.

In February, 1,690 new volunteers were selected and orientated to their roles within the extended project area. The process of selecting WHEs and the formation of care groups is crucial to assuring quality and success, as the WHEs are responsible for the teaching, support and home visits that result in community wide behavior change. Each WHE is responsible for 13-15 households near her own home. She must visit them every month to teach a specific health message, such as hand washing, to help mothers practice new skills, such as building and using a hand washing station, and also record vital information for the C-HIS. At the monthly care group meetings, WHE volunteers come together with a WR HFS member to report vital data, to discuss problems, and to learn and practice a new health message.

2. Baseline KPC, Focus Groups, LRA

The baseline Knowledge Practice and Coverage (KPC) survey and focus groups discussions were completed as part of the final evaluation of the original project in September 2002. In April 2003, a preliminary Local Rapid Assessment (LRA) survey on hand washing with soap was held to help prepare for the DIP. In March 2003, Doer/Non-Doer surveys were conducted for all interventions, in preparation for the DIP. Following extensive research within the communities and with assistance from WR headquarters, the DIP was completed in March. (See Section F for response to DIP.)

The first quarterly LRA was conducted in July 2003. In order to prepare for the first scheduled intervention, the LRA focused on immunization and enabled the project staff to critique and tailor the implementation strategy. It was also used to provide feedback to the project volunteers, MOH staff, village leaders (VLs) and communities in the project area. (See summary below and Annex C for full LRA.)

SUMMARY OF LRA FINDINGS FROM JULY 2003

	Baseline		LRA#1		EOP Goal	
	Old Area	New Area	Old Area	New Area	Old Area	New Area
Complete immunization for children	80.7%	13.6%	84.5%	51.3%	NO	NO
Complete immunization for children before 1 year	54.2%	12%	73.3%	36.2%	60%	60%
TT2 woman 15-49 years	71.7%	11.3%	82.6%	52.3%	NO	NO
TT2 for pregnancy woman	NA	NA	59%	12.7%	60%	60%

3. Information Education and Communication (IEC) Materials

In order to further strengthen capacity within the care groups, especially for WHEs with low literacy, the CE CSP contracted Action IEC to design new IEC materials for all interventions. The materials were field tested in April 2003, and final versions were sent to the project in May 2003. These new materials will be shared with other Child Survival projects in Cambodia at the next Combined Child Survival meeting scheduled for October 2003.

4. Intervention Implementation

During this first year of the CE CSP, the following interventions have been implemented: Immunization in February, Control of Diarrheal Disease (CDD) in May, and Micronutrients in September. Each intervention follows the same implementation process that is described below for Immunization.

In the new area, 81 Village Development Committees (VDCs), 248 VLs and 204 CGLs received a week long training on immunization. Topics covered were child immunization, post vaccination care of a child with a fever, maternal TT, the benefits of immunization, how to take care of the immunization card, and cord care of the neonate. This prepares the CGLs to train the WHE's in the care groups and helps the VDC and VL to support the WHEs in their community activities. Each intervention training also includes a section on management in order to build field management capacity of the VDC, VL and CGL over the life of the project.

The CGLs from both areas completed the immunization training with support from WHE supervisors and HFS. The training was divided into three, six-day sessions, which include field practice. After each session of the CG training, the WHEs share health messages with the mothers and households for which they are responsible.

The CE CSP has developed a one-page pictorial aid, which serves to help summarize key messages and also reminds WHEs of effective adult education methods that they can use when communicating with mothers.

In order to build the relationship between Health Center (HC) staff and the communities they serve, and to strengthen the health system, the HC staff are provided several scheduled opportunities to assist the HFS in training the WHEs. Through this training the HC staff have the opportunity to meet all the WHEs in their coverage area, and the WHEs are given the chance to advocate community needs to HC staff. This exchange also fosters understanding and mutual accountability. As a result of the relationship between the WHEs and HC staff, more villages responded and were included in recent MOH Expanded Program for Immunization (EPI) out reach activities, including villages that previously were ignored or suspicious of immunization.

Significant achievements: Progress made towards each of the program objectives

A. Capacity Building and Sustainability Objectives

Light for Life Objectives	Progress made?	Comments
1. 75% of salt vendors in the two largest market places will have iodized salt for sale and be able to describe why it is important.	Yes	Salt vendors will be trained in October 2003, according to the project schedule.
2. Community members will advocate for consistent outreach services (e.g. EPI) to district level authorities.	Yes	EPI outreach has extended to previously unvisited remote villages, however lack of MOH staff and Lack of MOH resources continues to be a challenge.
3. Attrition rate of trained volunteers for reasons other than death, disability or movement out of the project area will be less than 30%.	Yes	Currently, the volunteer attrition rate is 1.23% in the old area, and 4.2% in the new area. The project will continue to sponsor contests for achieving maximum immunization coverage, a tactic that has proven to motivate volunteers.
4. To integrate the WHEs and CG system into a lasting community structure: a) At least 75% of care groups will have 70% attendance at two of their last three meetings. b) In the final two years of the project, at least 65% of care groups will meet even when a HFS is absent. c) Integration of CG structure into the community via links with the village leader and Feedback Committee.	Yes	VDCs, VLs, and CGL are being trained to take responsibility for the care groups in the future.
5. 80% of EPI outreach sessions will be conducted according to schedule.	Yes	EPI outreach activity is currently measured at 90% to 100% in the old area, and f 62% to 92% in the new area.

6. Build mutual accountability between communities and the MOH as indicated by increased service utilization and the functioning of feedback committees.	Yes	Feedback committees are functioning. Two representatives per village have been selected to participate.
7. Integrate WR's community-based system with that of the MOH.	Yes	

B. Objectives for Technical Interventions

Light for Life Objectives	Progress made?	Comments
Immunization 1. Increase to 60% children age 12-23 months who are fully vaccinated before the 1 st birthday.	Yes	Immunization was selected as the first intervention for WHEs to be trained in. See LRA Annex C.
2. Increase to 60% pregnant women who will receive at least 2 TT doses before the birth of their child	Yes	See LRA Annex C.
Hygiene and CDD 3. Increase to 60% (80% old area) mothers who wash hands with soap in conjunction with at least two of the following: before preparing food, before feeding children, after defecation, & after attending to a child who has defecated.	Yes	All WHEs have been trained in this intervention.
4. Increase to 80% children with diarrhea who receive ORT.	Yes	Results from the CDD intervention will be included in next LRA.
Pneumonia CM 5. Increase to 40% the percentage of children with suspected pneumonia (rapid, difficult breathing) who were taken to a trained provider within 24 hours.		WHEs will be trained in February 2004, according to the project work plan.
<i>Sick Child</i> 6. Increase to 50% mothers who know at least 2 danger signs of childhood illness that indicate need for treatment.		WHEs will be trained in February 2004, according to the project work plan.
Nutrition 7. Increase initiation of breastfeeding within 1 hour of delivery to 40% (45% in old areas).	Yes	WHEs will be trained in September 2004, according to the project work plan. In response to DIP review recommendations, the CE CSP has increased targets for this indicator from 45% to 50% in the old area.
8. Increase to 30% use of iodized salt	Yes	HFS have started to train the WHEs in micronutrients (iodized salt, vitamin A)

9. Increase to 60% (80% in original villages) caretakers who will give more fluids and continue feeding a child who is ill.	Yes	Some of the key health messages (such as danger signs of that require referral of the child to the HC, ORT use, and extra fluids for a child who is ill) were included in the CDD training. Remaining messages are included in upcoming ARI training. The BCC team reinforces these messages through puppetry and drama.
10. 60% of children who completed the <i>Hearth</i> program achieve and sustain adequate or catch-up growth per month during at least 2 months after period of supervised feeding.	Yes	Hearth training scheduled to take place after the midterm evaluation.
11. Increase to 20% pregnant women taking iron tablets at least 60 days during most recent pregnancy.	Yes	VDCs, VLs, CGL were trained on this intervention. WHEs are scheduled to receive this training in November 2003.

In the first year, all activities specified in the DIP have been realized according to plan. This achievement was accomplished by a team that shows commitment, competency, community, compassion and creativity in the ongoing implementation of the cost extension CSP.

B. CHALLENGES

1. Transportation

CHALLENGE: In Dumbai there are many remote and isolated villages. The rainy season can affect travel as all roads used by project staff are dirt and can easily become muddy or flooded, making them impassable for the HFS.

RESPONSE: This situation is seasonal, July to October, and depends on the amount of rain. Sometimes there are longer alternate routes, boats can be used, and staff can stay overnight in the villages to minimize travel when conditions are difficult. The rains have been light this year, causing little disruption to project activities. Some VLs have submitted requests to the government and NGOs to improve their local road system.

2. Communication and Security

CHALLENGE: Security is continually improving but remote and isolated areas are still at high risk for robberies. All staff carry hand held radios, but due to the remote terrain and distances involved in Dumbai, radio coverage is not possible for the entire project area.

RESPONSE: BCC and HFS work in pairs to increase their security in areas where there is no radio contact. The HFS keep consistent schedules that are known by volunteers and VLs. They work with the staff to maximize their security. The villages value the CE CSP and the benefits it brings. This is reflected in the way villagers take care of HFS and warn them of any potential difficulties or security concerns.

3. Working with Village Leaders and Volunteers

CHALLENGE: In terms of building sustainability for care groups, VLs, VDC members, and CG leaders are being trained to take over some responsibility for care groups in their village. A major obstacle is a slow to grow “sense of community”, an ongoing effect from the years of genocide that fragmented Khmer society under the Pol Pot regime. The tendency to conceptualize beyond the individual level takes much time to cultivate, especially among the most poor. As the project director described, “They think about securing food more than community development.” Alcoholism is also a significant problem among VLs, again attributed to the extremely high levels of Post Traumatic Stress Syndrome measured within Cambodia’s post conflict society.

RESPONSE: Sustainability is an ongoing issue for HFS in the old area. They are constantly looking for ways to build sustainability both through the MoH, HCs, FBC and local VLs. The CE CSP looks to partners and other projects for examples of successful sustainability, in addition to testing strategies of their own. For example, intervention contests seem to be effective in that they develop the concept of group effort to achieve clear results. The contests cultivate a spirit of initiative that the CE CSP hopes to continue building upon.

Another strategy for sustainability has been for the project to engender key life values within its staff, such as compassion empathy, patience and love. These values are then reflected in how they train volunteers, interact with VL, HC & MOH staff, and do their job in the field. The staff are a model to all those who they work closely with. The goal is that through this modeling, key community members will come to see and understand the role they need to take in becoming responsible for the future of the care groups.

4. The MOH and the Health Center

CHALLENGE: The Dambai HC is over burdened with responsibility for a high number of remote villages, and does not have enough staff to complete out reach activities. The MOH lacks funds to meet transportation costs.

RESPONSE: The CE CSP consistently advocates at the provincial level for more staff to be allocated to Ponhea Kriek-Dambai district. The efforts have resulted in a few additional staff members assigned to the project area. The project provides gasoline for the MOH EPI out reach and transportation for the feed back committees to travel for monthly meetings with at the HCs. Once the district is contracted out next year, the contracting agency will meet this need.

C. NEED FOR TECHNICAL ASSISTANCE

Priority	Program Application
1. Sustainability Research	To build the capacity of the project manager to maximize project sustainability in old area.
2. Financial management	To maximize effective project financial management.
3. Curriculum development	To strengthen the skill of the staff in terms of Job Aids.

4. English	To enable the managers to do international communication such as report writing, regional workshops, etc.
5. Computer Skills	To help program staff in efficient planning and report writing.

D. SUBSTANTIAL CHANGES FROM PROGRAM DESCRIPTION OR DIP

At this time, the CE CSP reports no significant changes.

E. & F. RECCOMENDATIONS MADE IN RESPONSE TO THE DIP.

In response to a recommendation made by DIP reviewers, the project changed the target goal for early initiation of breastfeeding from 45% to 50%, as shown in the table below:

Nutrition 7. Increase initiation of breastfeeding within 1 hour of delivery to 40% (50% in old areas).	a. Training WHEs and caretakers via CG structure and home visits. b. BCC teams reinforce messages, also reaching children and men. c. Training of TBAs.
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RESPONSE TO RECOMMENDATIONS MADE IN FINAL EVALUATION:

The table below summarizes recommendations made during the final evaluation of the first CS project, and reports progress made toward implementing those recommendations.

Recommendation	Progress made	Comments
TRAINING		
Use Original Care Groups as demonstration sites for training new care group members to become “trainers”.	Yes	49 CGLs were selected to become trainers. They will lead demonstration training for new care group members.
Reduce the drip training from 2.5 days straight days to 2 hours at a time, with 2 hours field practice, once a week for three weeks. Smaller drops.	Yes	
Mothers who want to become volunteers should be encouraged and mentored by a care group leader or another volunteer, to spread the news.	Yes	Mothers who wanted to become volunteers were selected and mentored by the WHEs.
Involve VLs in a “special training” to learn more about the technical training and give them a copy of lesson plans and IEC materials for reference. Train them how to train men.	Yes	The project trains VDC, VL, and CGL separately in each intervention and encourages them to teach the men. They

		are given Health lessons and IEC materials to share.
C-HIS		
Devise ways to present the data to the VLs and CGLs. Involve them in the process to have their input. A possible example: for percentages use 10 stick figures or a group of houses.	Yes	The CE CSP has developed new visuals for communicating C-HIS data to community leaders.
COMMUNITY MOBILIZATION		
Continue to keep credit out of the care groups. This will change the focus away from health and lead to other problems.	Yes	The CE CSP care groups are not credit groups.
Rather than wait for another NGO to develop the VDC, start working with other non-formal leaders to garner support and community involvement in village level health directions and decisions.	Yes	Feed back committees were developed. The CE CSP plans to assist with revitalizing VDCs.
Advocate at the policy level the expanded EPI to integrate other services at the EPI sessions such as family planning, growth monitoring and PNC.	No	Project staff attended the NIP workshop concerning strengthening EPI services. The contracting agency will be responsible for adding the additional services.
HEALTH CENTER		
Continue EPI contest once a year.	No	The next EPI contest will occur in 2004, once all new villages are on a regular EPI schedule.
Operational District hospital staff should be trained in methods to motivate the HC staff to do their work.	No	The contracting agency will be responsible for hospital staff training.
Request MOH (PP and provincial) to staff more of the HC.	Yes	The project has advocated for additional staff, resulting in few more being allocated PK/Dambai district.

Provide a workshop for HC staff (assistant volunteers) to train them like the WHEs.	No	The project has involved the HC staff in WHE training, making it an integrated effort. This collaboration is more affective and less threatening than a training workshop for the HC staff, who are considered professionals.
Provide BS and HIV/VCT training for HC staff.	No	The CE extension focuses on IMCI in an extended area and does not focus on BS or HIV/AIDS.
WR should continue to subsidize gas for EPI teams until contractor wins bid for OD.	Yes	Until the contracting NGO assumes responsibility, the CE CE CSP continues to subsidize the EPI outreach.
Autodisposal syringes are coming in 2003 from the MOH. Motivate the EPI teams to properly dispose of needles (in incinerator or well) and to keep antiseptic. Provide tools to pick up the sterilized goods. If practices are not followed properly, report to HC director, not directly to team.	Yes	Autodisposal syringes are used by the EPI teams (they use the safety box to transport used needles for disposal in the provincial incinerator). Some HCs have wells for needle disposal.

G. MANAGEMENT SYSTEMS

1. Financial Management

The CE CSP benefited from improvements made within WR during the FY03 fiscal year. A systems upgrade and new software enables more flexibility and detail in financial tracking. This change, combined with training for the CS accountant, has enabled the project and country office to better manage the CS budget and to track expenses in a more timely manner.

2. Human Resources

WR's matrix structure provides support to the CE CSP from two complementary approaches. The WRC country office in Phnom Penh provides general program management, administrative oversight and financial management and the WR headquarters technical team offers specific technical support relating to program approach and interventions. Melanie Morrow, MPH, Child Survival Specialist, is the primary WR headquarters contact for the CE CSP. (See Annex A).

The CE CSP program manager and the assistant manager/trainer are well trained by CSTS and Kay Hansen (the original project director) in program management, implementation, monitoring, and evaluation. Within the expanded project area, the CE CSP management staff assigned care group responsibilities among the HFS in such a way as to maintain equity in the workload and travel required of the HFS, so that they continue to work as a cohesive team. The HFS train and support the volunteer WHE care groups and CGLs. The WHEs conduct the home visits and collect vital statistics through the C-HIS each month. They are the primary agents for behavior change in communities and are true leaders for grass roots development. All staff use monthly checklists and report forms in order to monitor and document performance. Staff turnover has not been a problem, as all staff initially hired still work for the CE CSP, except one, who has died.

3. Communication System and Team Development

Communication with headquarters is less cumbersome and more frequent now that the Ponhea Kriek office is able to receive mobile phone service and can download e-mail. Access to the internet is available at the country office in Phnom Penh.

The CE CSP has designated one working day per week for team building exercises, problem solving and weekly planning. Since new staff members have been added, these team building days have been crucial in developing cohesion. Since the BCC team members work to reinforce the messages delivered through home visits, it is necessary to have regular interaction among the staff, so that they can discuss challenges, refine communication strategies, and support each other.

4. Relationship with Local Partners

Relationships between WR Child Survival and local partners continued to be strengthened throughout the first year of the CE CSP. The project continues to dialogue with the district MOH and other partners in coordinating outreach activities, to develop complementary strategies, and to build capacity within Cambodia's health system. While there has been no formal review or evaluation conducted by partners, feedback is received in various ways, as shown in the chart below.

PARTNERS	FEEDBACK
1. MOH	MOH communicated with NGO/PVOs at the national workshop where they discussed program results and gaps.
2. Provincial health director	Feedback given to NGO/PVO community at the Procom meeting.
3. Operational health district director and other	Formal and informal meetings provide

officials.	consistent feedback from the director.
4. Health center staff	By involving HC staff in WHE training and other project activities, the CE CSP receives their feedback and a sense of mutual accountability develops between both parties.
5. The local authority	Formal and informal meetings.
6. The community	The CE CSP gets feedback from the community through monthly meetings, home visits and during focus group interviews.
8. The NGOs working in the region with the CE CSP such as CHE, and the future contracting agency.	Through meetings, working groups and workshops, CE CSP gains insight from other projects.
9. Sey La (VDCs)	By inviting Sey La to staff training, and asking them to participate in community interviewing and WHE's monthly meetings, the project staff benefits from their feedback.
10. The local USAID mission	Though periodic meetings.

H. WORK PLAN

Abbreviations Key:

HH = household; C = community; HF = health facility; D = district; WHE = Women Health Educators; HFS = health field staff; CG = care group; VL = village leaders; VDC=village development committee

October 2003-October 2004

Date	Activities Planned by Level	Target Groups	Responsible Person
Oct 2003	YEAR 2		
6-17	EPI outreach: HH: mobilize women to take children for immunizations C: mobilize community; invite village leader HF: provide outreach services D: coordinate, supervise and support HF services	Women, children grannies, VDC, VL, Women, children MOH staff	WHE, WHE's supervisors WHE, WHE's supervisors, HFS D, MOH staff D, MOH staff
6-17	WHE to HH old area	Mothers and children	WHE, HFS
4-12 Sept	Micronutrient training for leaders in New Area C: Micronutrient training for care group and VLs, VDC	VL, VDC, CG leaders	HFS, WHE supervisors, project supervisors, training coordinator
1-9 Oct	Micronutrient Training #1, New Area HH: after training WHE do home visits C: train WHE in EPI, C-HIS collected HF: MOH staff invited to join	WHE, mothers, children and grandmothers same as above same as above	HFS, WHE supervisors, project supervisors, training coordinator
10-29	LRA and CG contest on CDD HH: surveys C: WHE help facilitate surveys, feedback to WHE, CG, VL and VDC. Small price given to CG. HF: feedback to MOH staff D: Feedback to district leaders and other leaders	Women, children HFS. Feedback given to WHE, CG, VL, VDC, MOH, staff, district MOH leaders, HFS and project management	HFS, WHE facilitate surveys, project supervisors, project management team
20-29	Care group meeting old area: C: WHEs collect C-HIS data, discuss stats and impact from last C-HIS data, discuss problems, review health messages	WHEs	WHEs, HFS

30-31	Compile C-HIS – provide feedback: HFS and supervisors compile data provide feedback to: C: C-HIS feedback to VL, VDC, CG leaders and WHE HF: HIS to HCs D: C-HIS to district leader, MOH district manager, commune leaders	C: VL, VDC, CG, WHE HF: MOH staff D: district MOH and other district leaders	Project supervisors, HFS
6, 13, 20, 27	Weekly staff meetings: Team building, problem solving, lesson development, training	Project staff	HFS, HFS supervisors, BCC promoters, BCC supervisor, management
Nov 2003			
3-14	WHE to HH in old area – same as above	Mothers and children	WHEs, HFS
4-13	Micronutrient Training #2, New Area HH: after training WHE do home visits C: train WHE in EPI, C-HIS collected HF: MOH staff invited to join	WHE, mothers, children and grandmothers same as above same as above	HFS, WHE supervisors, project supervisors, training coordinator
3-14	EPI outreach HH: mobilize women to take children for immunizations C: mobilize community; invite village leader HF: provide outreach services D: coordinate, supervise and support HF services	Women, children grannies, VDC, VL, Women, children MOH staff	WHE, WHE's supervisors WHE, WHE's supervisors, HFS D, MOH staff D, MOH staff
12-14	Micronutrient training for new WHE in old area all sessions HH: after training WHE do home visits	WHE, mothers, children and grandmothers same as above same as above	HFS, WHE supervisors, project supervisors, training coordinator
17-27	Care group meeting old area: C: WHEs collect C-HIS, discuss stats and impact from last C-HIS, discuss problems, review health messages	WHEs	WHEs, HFS
18-21	Review micronutrients with WHEs in the old area	WHE	HFS, project supervisors

28-Dec 1	Compile C-HIS – provide feedback: HFS and supervisors compile data provide feedback to: C: C-HIS feedback to VL, VDC, CG leaders and WHE HF: C-HIS to HCs D: C-HIS to district leader, MOH district manager, commune leaders	C: VL, VDC, CG, WHE HF: MOH staff D: district MOH and other district leaders	Project supervisors, HFS
3, 10, 17, 24	Weekly staff meeting Team building, problem solving, lesson development, training	Project staff	HFS, HFS supervisors, BCC promoters, BCC supervisor, Management
Dec 2003			
1-18	WHE to HH all areas	Mothers and children	WHEs, WHE's supervisors, HFS
1-3	MOH staff train HFS in Pneumonia case management	HFS	MOH staff, project supervisors, management
4-5	Prepare lessons for ARI and sick child	Same as previous lesson preparation	Training coordinator, assistant
8-19	EPI outreach HH: mobilize women to take children for immunizations C: mobilize community; invite village leader HF: provide outreach services D: coordinate, supervise and support HF services	Women, children grannies, VDC, VL, Women, children MOH staff	WHE, WHE's supervisors WHE, WHE's supervisors, HFS D, MOH staff D, MOH staff
15-30	Care group meetings, all areas C: WHEs collect C-HIS, discuss stats and impact from last C-HIS, discuss problems, review health messages	WHEs	WHEs, WHE's supervisors, HFS
31	Compile C-HIS – provide feedback: HFS and supervisors compile data provide feedback to: C: C-HIS feedback to VL, VDC, CG leaders and WHE HF: C-HIS to HCs D: C-HIS to district leader, MOH district manager, commune leaders	C: VL, VDC, CG, WHE HF: MOH staff D: district MOH and other district	Project supervisors, HFS
1,8,15,22,29	Weekly staff meeting as previous	Project staff	HFS, HFS supervisors, BCC promoters, BCC supervisor, management

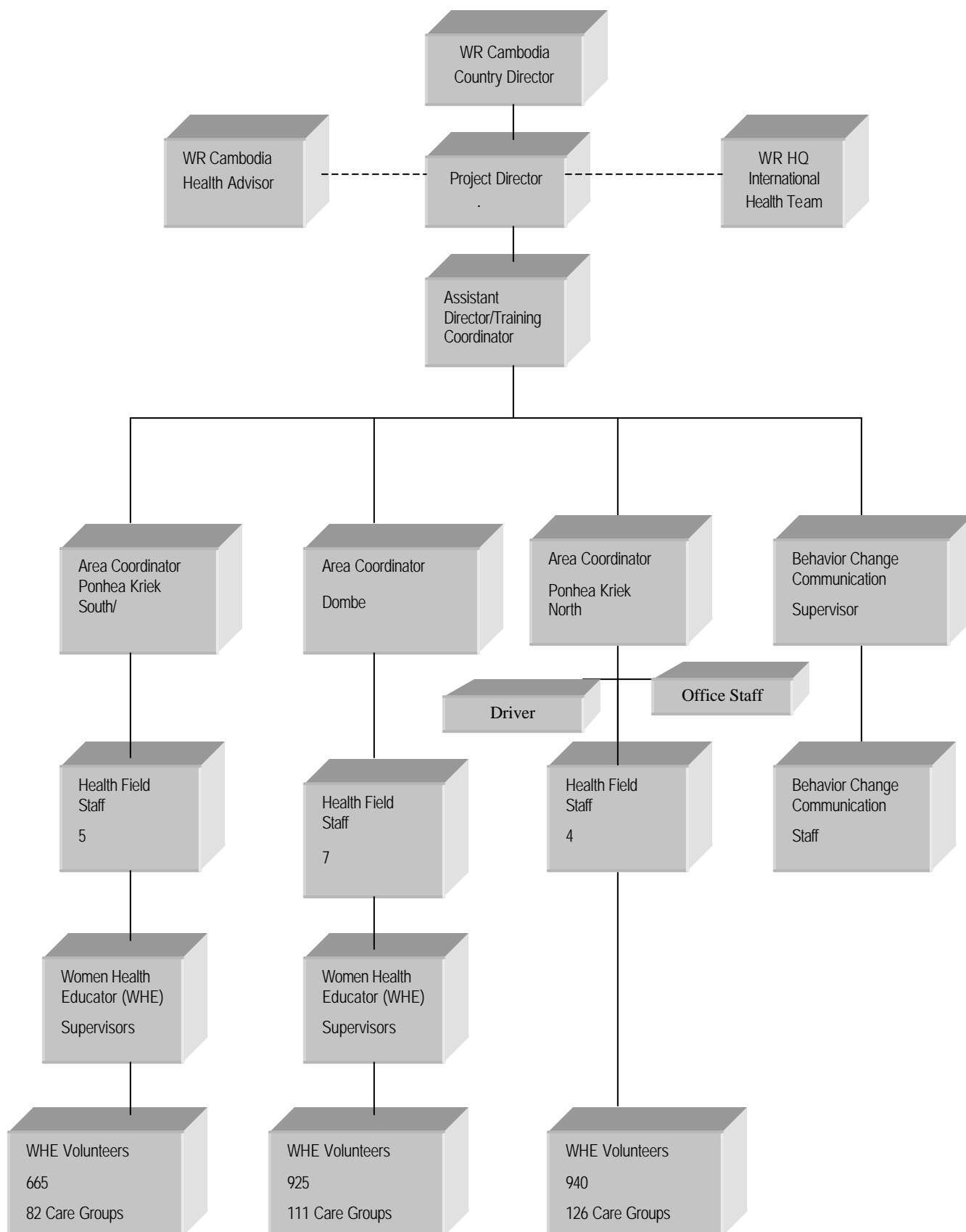
Jan 2004			
5-29	LRA and Micronutrient contest, all areas – Same as other contests	Women, children, HFS. Feedback given to WHE, CG, VL, VDC, MOH staff, district MOH, HFS	HFS, project supervisors, management team
5-16	EPI outreach	Same as previous	Same
1-16	WHE to HH all areas	Same as previous	Same
15-28	Care group meetings	Same as previous	Same
29-30	Compile C-HIS – provide feedback	Same as previous	Same
2, 9, 16, 23, 30	Weekly staff meeting	Same as previous	Same
Feb 2004			
2-5	Finish LRA and contest – same as above	Same as previous	Same
9-11	Train leaders in ARI and sick child, new area	Same as other leader training sessions	Same
9-20	EPI outreach	Same as previous	Same as previous
2-13	WHE to HH old area	Same as previous	Same
12-23	ARI training session #1 to WHE in new area – same as other training	Same as other training	Same
24-26	ARI session #2 WHE in new area – same as other training	Same as other training	Same
16-26	Care group meetings	Same as previous	Same as previous
27-Mar 3	Compile C-HIS – provide feedback – same as previous months	Same as previous	Same
6, 13, 20, 27	Weekly staff meeting – same as previous months	Same as above	Same
Mar 2004			
2-4	ARI session #3 to WHE in new area – same as ARI #1	Same as other training	Same
8	Train leaders in ARI and sick child, old area – same all previous leader training	Same as all previous leader training	Same
9-15	ARI session #1 to WHE in old area – same as above	Same as above	Same
16-22	ARI session #2 to WHE in old area – same as in new area	Same as new area	Same
23-31	MOH train WHE all areas in ARI and sick child – same as above for MOH training of WHE	Same as above	Same
8-19	EPI outreach – same as all previous	Same as previous	Same
1-18	WHE to HH in new area – same as previous	Same as previous	Same
15-29	Care group meetings – same as previous	Same as previous	Same

30-31	Compile C-HIS – provide feedback-same as previous	Same as previous	Same
5, 12, 19, 26	Weekly staff meeting – same as previous months	Same as previous	Same
Apr 2004			
1-6	MOH train WHE all areas in ARI and sick child– same as previous MOH training	Same as previous	Same
5-9	Staff workshop – project	Project staff	Project management
5-16	EPI outreach – same as previous	Same as previous	Same
1-16	WHE to HH all areas – same as previous	Same as previous	Same
19-29	Care group meetings in all areas – same as previous	Same as previous	Same
30	Compile C-HIS – provide feedback –same as previous	Same as previous	Same
2, 9, 16, 23, 30	Weekly staff meeting – same as previous	Same as previous	Same
May 2004			
3-27	LRA, ARI and sick child contest, all areas – same as previous	Same as previous	Same
4-14	EPI outreach – same	Same as previous	Same
3-14	WHE to HH, all areas – same as previous	Same as previous	Same
17-27	Care group meetings in all areas – same as previous	Same as previous	Same
28-31	Compile C-HIS – provide feedback -same as previous	Same as previous	Same
7, 14, 21, 28	Weekly staff meeting -same as previous	Same as previous	Same
June 2004			
1-14	LRA, ARI and sick child contest, all areas -same as	Same as previous	Same
15-18	Nutrition training for HFS – project	HFS to benefit mothers, children, WHE, VL, VDC	Training coordinator, management team
21-25	Prepare Nutrition lessons – same as other lessons	Same as previous	Training coordinator, assistant
7-18	EPI outreach –same as previous	Same as previous	Same
1-17	WHE to HH all areas –same as previous	Same as previous	Same
15-28	Care group meetings in all areas – same as previous	Same as previous	Same
29-30	Compile C-HIS – provide feedback –same as previous	Same as previous	Same
July 2004			
1-7	Drug seller training	Drug sellers	HFS, project supervisors, management team
8-15	TBA training on post-natal care	TBA	HFS, project supervisors, management team
5-16	EPI outreach –same as previous	Same as previous	Same

5-16	WHE to HH all areas –same as previous	Same as previous	Same
19-29	Care group meetings, all areas – same as previous	Same as previous	Same
30-2 Aug	Compile C-HIS – provide feedback –same as previous	Same as previous	Same
Aug 2004			
3-26	Annual LRA – same as other LRA	Same as previous	Same
23-26	Assess drug seller training HH: survey users of drug suppliers	Women and children, drug sellers	Project supervisors, management team
9-20	EPI outreach – same as above	Same as previous	Same
2-13	WHE to HH, all areas – same as above	Same as previous	Same
16-26	Care group meetings, all areas – same as above	Same as previous	Same
30-31	Compile C-HIS – provide feedback (same as above)	Same as previous	Same
6, 13, 20, 27	Weekly staff meetings – same as above	Same as previous	Same
Sept 2004			
1-7	Nutrition training for leaders in new area – same as for other leader training	Same as previous	Same
8-16	Nutrition session #1 new area – same as other training sessions	Same as previous	Same
20-28	Nutrition session #2 new area – same as above	Same as previous	Same
6-17	EPI outreach – same as above	Same as previous	Same
6-17	WHE to HH old area – same as above	Same as previous	Same
15-28	Care group meetings in old area – same as above	Same as previous	Same
29-30	Compile C-HIS – provide feedback (same as above)	Same as previous	Same
3, 10, 17, 24	Weekly staff meeting – same as above	Same as previous	Same

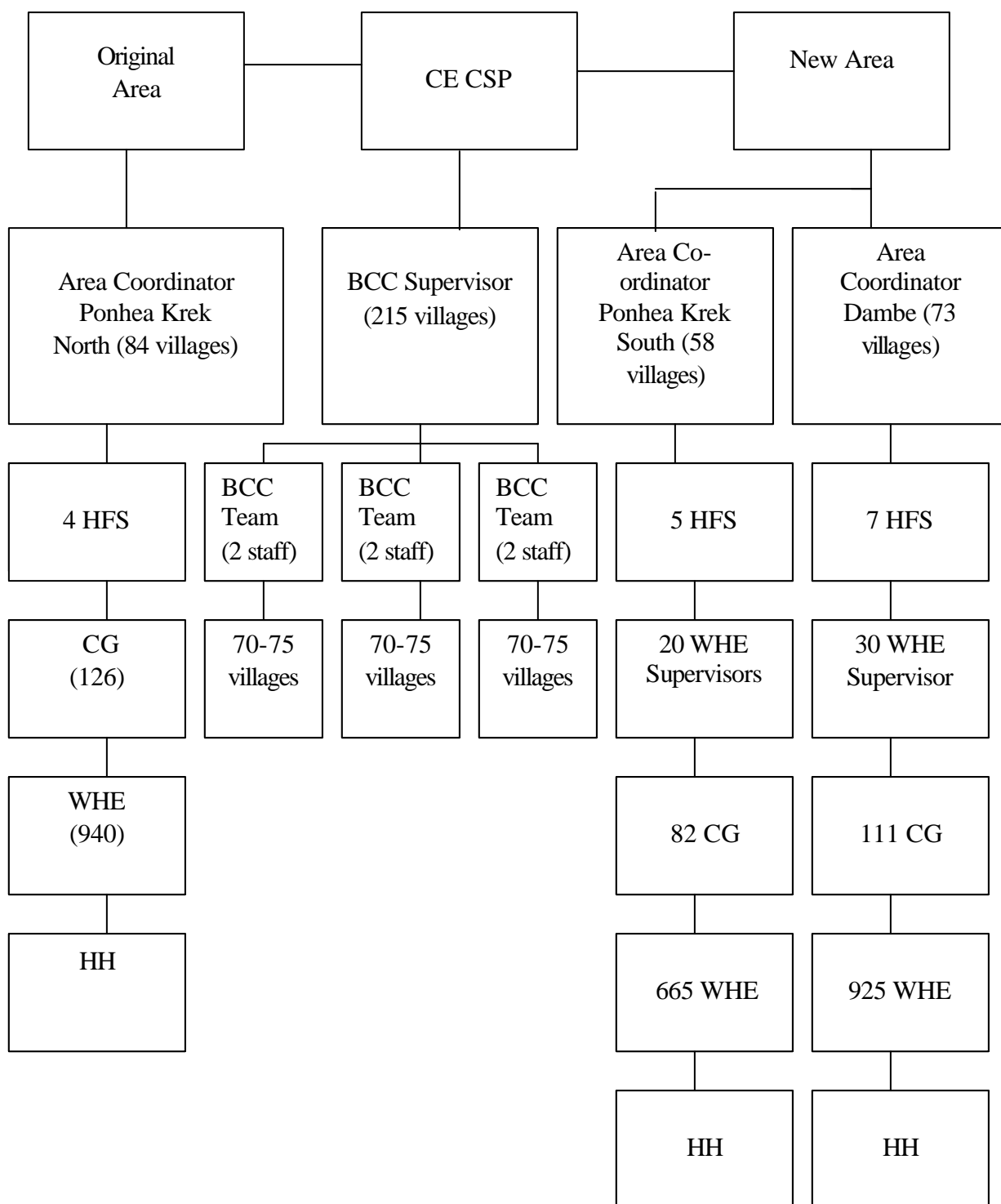
ANNEX A

Organizational Chart Light For Life Cost Extension



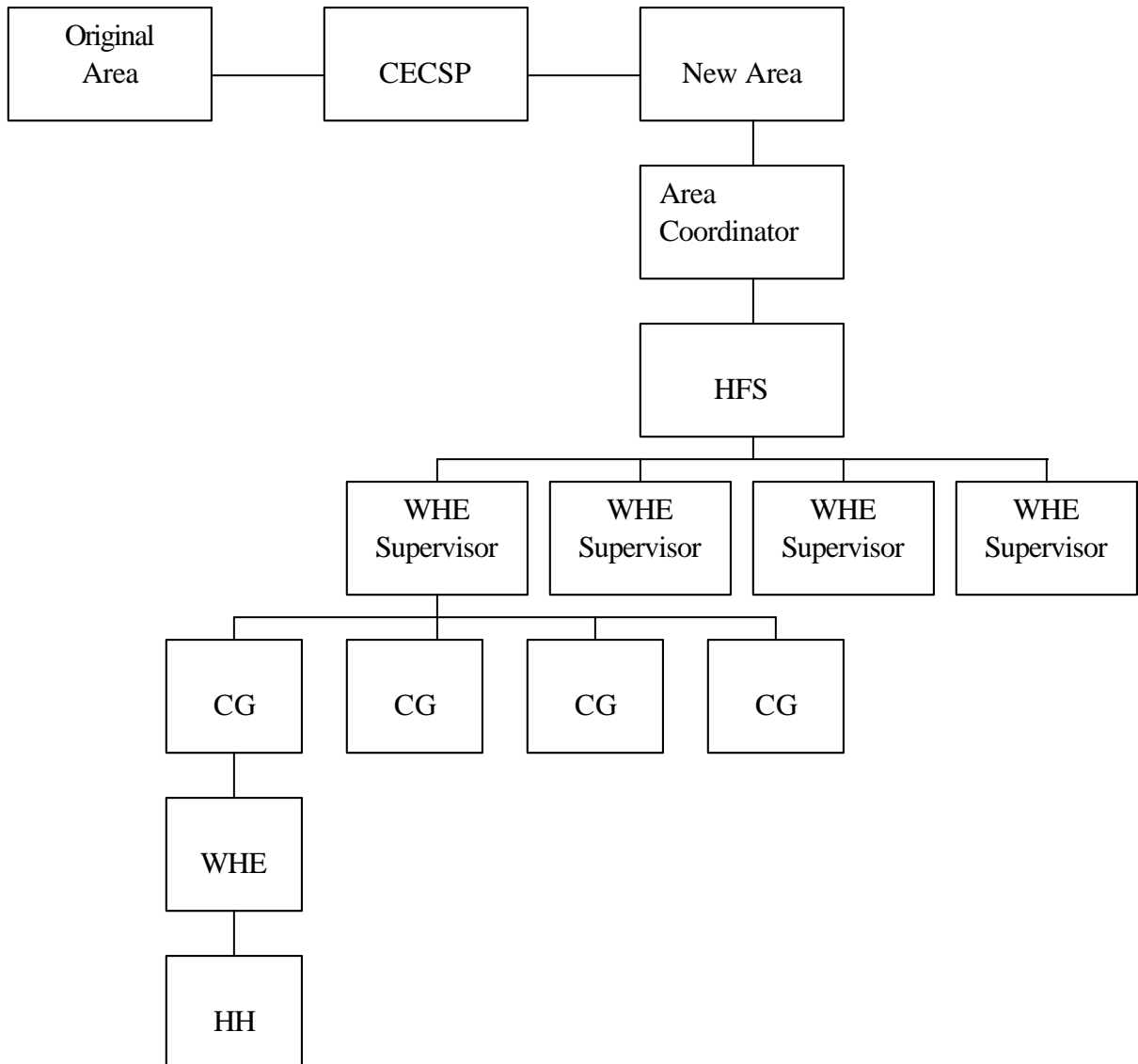
ANNEX B

FIELD RESPONSIBILITY STRUCTURE



ANNEX B (continued)

Detailed Information on one of the community responsibility structures in the new area:



ANNEX C

World Relief Cambodia
Light for Life Cost Extension Child Survival Project
Ponhea Kriek District, Kompong Cham Province
First Local Rapid Assessment - July 2003

I. Objectives of the Local Rapid Assessment Survey

The purpose of this mini-survey is to help the project focus on goals and achievements for reflection and discussion. It is primarily to help locate problem areas at both the project level and among HFS. It is also used to provide feedback to the project volunteers, MOH staff, and leaders of villages and communes in the project area.

II. Sample Selection

Each HFS chose three care groups by drawing lots from a box. To avoid bias, the HFS interviewed mothers from another HFS's care groups, not from their own. Three WHEs were randomly selected for each of the chosen care groups. The first and the second WHE selected were responsible for 2 women with children under 2 years, the other WHE was responsible for 3 women with children under 2 years. This gave a total of 7 women interviewed in each care group, with a total of 21 women interviewed per HFS. In order to have a large enough sample to measure EPI coverage, other care groups were included, allowing at least 21 women with children 12- 23 months for each HFS and HC.

In the old area, mothers with children of age 12-23 months were selected to interview regarding immunization practices and coverage.

III. Method of Data Analysis

Data entry and processing was done by Phan Seang Thuen, Phan Buntheng, and Oun Sivan with EPI Info 6.

IV. Survey Results

The following answers were given for the survey questions. The total number of this survey in LRA1 was 469, including 161 in the old area and 308 in the new area. There are two kinds of survey forms. In the old area, only the practice and the coverage questionnaires were given to the mothers. In the new area, the knowledge questionnaires were added to the survey used in the old area to measure the knowledge of the mother who just gets training for a few months.

Demographic Data

OLD AREA: N=161

1. Do you know your volunteer?
 - a. Yes = 98.8%
 - b. No = 1.2%

2. Age range of women is 18-47 years, with the age mean of 28.056 years.

3. Name, age, and sex of a youngest child.
 Male = 48.4%, Female = 51.6%, Child Age Range: 12-23 months, Age Mean: 17.025

4. Ask the mother to see the yellow card of her child. Look at the child's immunization card and record the dates of all immunizations for each vaccine shown on the card in the space below. Put yes if the card shows a vaccination was given but no date was recorded.

Children 12-23 months: N = 161

Response	Baseline N=118		LRA1 N=161	
	N	%	N	%
BCG	98	83.1%	147	97.5%
OPV1	97	82.2%	156	96.9%
OPV2	92	78%	150	93.2%
OPV3	83	70.3%	146	90.7%
DPT1	97	82.2%	156	96.9%
DPT2	93	78.8%	150	93.2%
DPT3	83	70.3%	146	90.7%
Measles	90	76.3%	137	85.5%
Immunization Complete	81	68.6%	136	84.5%
Immunization Complete before 1 year of age	64	54.2%	118	73.3%
OPV drop out rate	14.4%		6.4%	
DPT drop out rate	14.4%		6.4%	

5. Look at the maternal health card or other immunization record and record the dates for each TT shown on the card below:

Response	Baseline N=300		LRA#1 N=161			
	TT2 woman with age 15-49 years		TT2 woman with age 15-49 years		Woman got TT2 before the birth of their child	
	N	%	N	%	N	%
No card/lost	134	44.7%	24	14.9%	52	32.3%
TT1	166	55.3%	137	85.1%	109	67.7%
TT2	150	50%	133	82.6%	95	59%

TT3	95	31.7%	108	67.1%	55	34.2%
TT4	31	10.3%	46	28.6%	13	8.1%
TT5			10	6.2%	4	2.5%

Demographic Data

NEW AREA: N = 308

1. Do you know your volunteer?
 - a. Yes = 97.4%
 - b. No = 2.6%
2. Name, age of the mother.
Age range of the woman is 18-45 years, with the age mean of 28.143 years
3. Name, age, and sex of the youngest child.
Age range of the woman is 3-23 months, with the age mean of 15.016 years
Male = 50%, Female = 50%
4. What are the 6 preventable diseases?

Response	LRA1 N= 308	
	N	%
Tuberculosis	253	82.1%
Polio	286	92.9%
Pertussis	259	84.1%
Diphtheria	229	74.4%
Tetanus	267	86.7%
Measles	280	90.9%
Don't know	11	3.6%
Know all 6 preventable diseases	201	65.3%

5. After a child receives vaccine, then he/she has a fever, what do you do to help him/her?

Response	LRA1 N= 308	
	N	%
a. Give paracetamol	294	95.5%
b. Cover the wet cloth	176	57.1%
c. Don't know	9	2.9%
Know 2 (a, b) ways	169	54.9%

6. Ask the mother to see the yellow card of her child. Look at the child's immunization card and record the dates of all immunizations for each vaccine shown on the card in the space below. Put yes if the card shows a vaccination was given but no date was recorded. Select the child with age 12-23 months only for the immunization.

Response	Baseline N=125		LRA1 N=260	
	N	%	N	%
BCG	40	32%	195	75%
OPV1	38	30.4%	195	75%
OPV2	29	23.3%	177	68.1%
OPV3	22	17.6%	150	57.7%
DPT1	37	29.6%	193	74.2%
DPT2	29	23.2%	174	66.9%
DPT3	22	17.6%	151	58.1%
Measles	21	16.8%	150	57.7%
Immunization Complete	17	13.6%	133	51.3%
Immunization Complete before 1 year of age	15	12%	94	36.2%
OPV drop out rate	42.1%		23%	
DPT drop out rate	40.5%		21.7%	

7. Look at the maternal health card or other immunization record and record the dates for each TT shown on the card below:

Response	Baseline N=300		LRA#1 N=308			
	TT2 woman with age 15-49 years		TT2 woman with age 15-49 years		Woman got TT2 before the birth of their child	
	N	%	N	%	N	%
No card/lost	252	84%	110	35.7%	241	78.2%
TT1	49	16.3%	198	64.3%	66	21.4%
TT2	34	11.3%	161	52.3%	39	12.7%
TT3	15	5%	77	25%	16	5.2%
TT4	1	0.3%	20	6.5%	4	1.3%
TT5	0		4	1.3%	3	1%

V. Discussion and Recommendations

Most of the women knew their WHE volunteer. Old area 98.8%, new area 97.4%.

IMMUNIZATION

Knowledge of immunization:

The knowledge of immunization was measured only in the new area. The survey shows that 65.3% of mothers know all the 6 preventable diseases, and 54.9% know two ways (give paracetamol, cover the child with a wet cloth after receive the vaccines) to reduce fever. There are many villages in the expanded area that previously had no knowledge of immunization. While the project is already measuring increased knowledge, there is much work to be done in order to reach EOP goals.

Complete Child immunization before 1 year:

The survey shows that the children with the yellow card and complete immunization before 1 year was 73.3% in the old area, and 36.2% in the new area. This is a significant improvement from the baseline of 54.2% in the old area, and 12% in the new area.

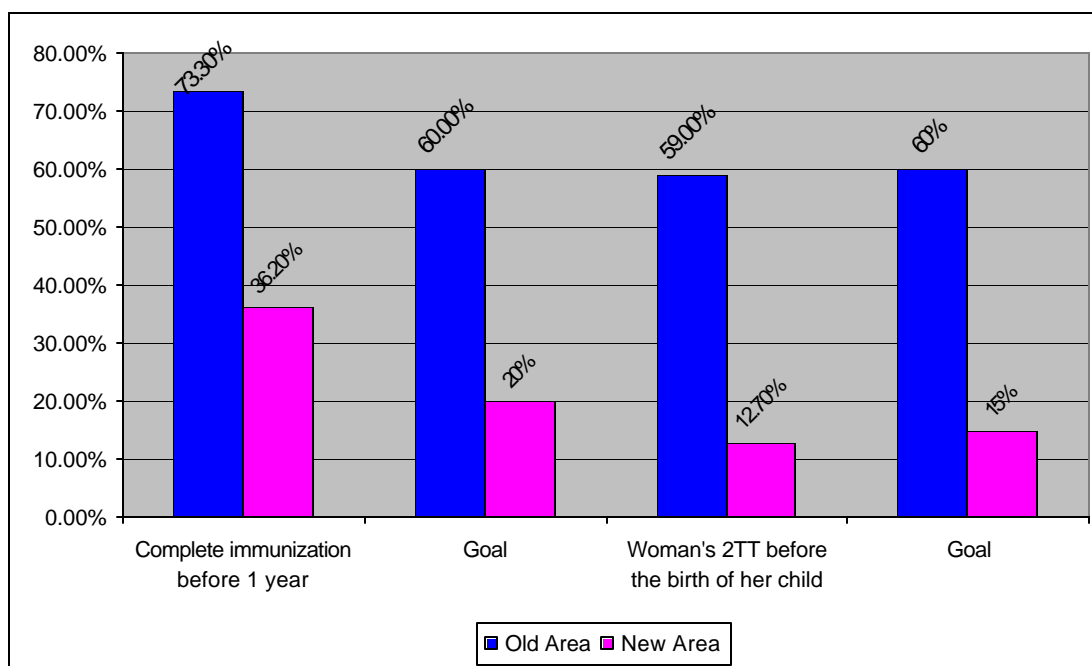
The drop out rate of OPV and DPT is quite different in both areas. OPV and DPT are 6.4% in the old area compared to 23% and 21.7% of in the new area, indicating that knowledge and behavior change has sustained in the old area even though there are fewer WR staff monitoring care group activities.

Maternal 2TT before the birth of the last child:

As referenced by the yellow card, 59% of women had at least 2 doses of tetanus toxoid (TT) before the birth of her last child in the old area, which nearly reaches the goal of 60%. In the new area, 12.7% of women had 2 TTs before the birth of her last child. Coverage in the new area falls short of the 15% goal for year one of the project, which is not surprising as remote villages still do not receive EPI outreach services. The WHEs continue to educate their neighbors about immunization lessons and work to bolster MOH outreach services. The project has included a training session about how to preserve the yellow card, since this was identified by the mothers to be a challenge.

Comparison of the old area and the new area:

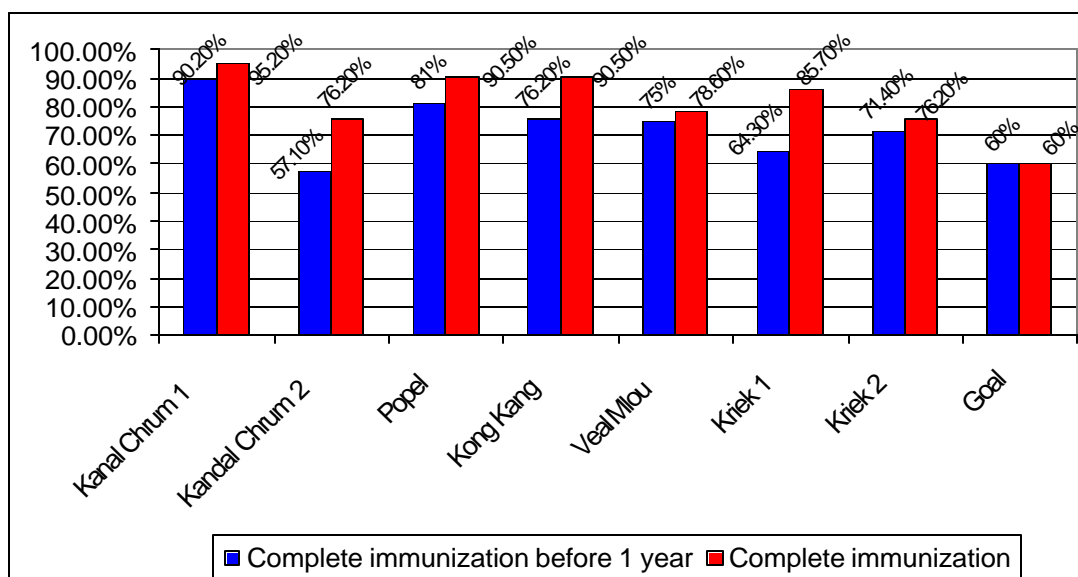
Graphic 1: Complete immunization before 1 year and Woman's 2TT before the birth of her child.



Comparison of Health centers:

The following graphs show the comparison between the different HCs in key elements of this survey. These results were shared with the district, commune and VLs, MOH and care groups.

Graph 2: Compare child complete immunization and child complete immunization before 1 year by each HC in the old area.



In the old area, 6 out of 7 HCs meet the project goal, only Candual Chrum 2 (57.1%) falls short of the 60% goal.

The OPV and DPT drop out rates have decreased considerably in all communes and lower than 10%, except Kandual Chrum2 is 11.11%.

<u>Health center</u>	<u>OPV drop out rate</u>	<u>DPT drop out rate</u>
Veal Mlou	7.69%	7.69%
Popel	9.52%	9.52%
Kandal Chrum1	4.76%	4.76%
Kandal Chrum2	11.11%	11.11%
Kong Kang	9.52%	9.52%
Kriek1	3.57%	3.57%
Kriek2	0%	0%

The women who have received at least two doses of TT vaccines before the birth of her last child show that Kandual Chrum1, Kandual Chrum2, Popel, and Kriek2 meet the project goal of 60%. The other three HCs such as Kriek1, Veal Mlou, and Kong Kang did not meet the goal, but the 2TT of the women between 15-49 years is high compare to the women 2TT before the birth of her child.

Health center	Woman's 2TT 15-49 years	Maternal 2TT before the birth of last child
Veal Mlou	60.7%	17.9%
Popel	90.5%	81%
Kandal Chrum1	90.5%	66.7%
Kandal Chrum2	85.7%	71.4%
Kong Kang	90.5%	57.1%
Kriek1	82.1%	53.6%
Kriek2	85.7%	81%

In the new area

In the new area, there are 7 HCs. Mothers with children 12-23 months were interviewed and dates of each vaccine were recorded from the yellow card. The survey shows 6 of 7 HCs (Dambai, Chung Cheag, Tropaing Pring, Pon Lay, Ta Am, Don Tey) exceed the first year goal of 20% complete immunization before 1 year. The remaining HC Tuk Chouv is 16.7%. But the increase from the baseline of 12% to 16.7% is encouraging. The following table below shows detail in comparing the HCs.

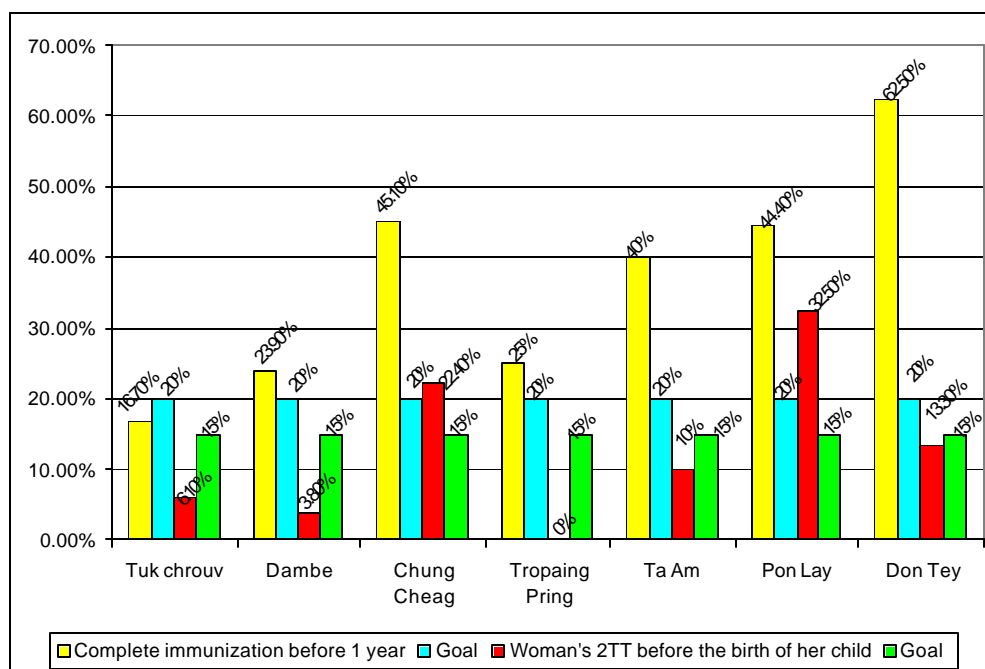
Response	Tuk Chouv	Dambai	Chung Cheag	Tropaing Pring	Pon Lay	Ta Am	Don Tey
BCG	56.7%	61.2%	76.5%	83.3%	88.9%	80%	93.8%
OPV1	56.7%	59.7%	76.5%	83.3%	91.7%	80%	93.8%
OPV2	46.7%	50.7%	74.5%	70.8%	80.6%	80%	90.6%
OPV3	30%	38.8%	72.5%	62.5%	63.9%	70%	81.3%
DPT1	56.7%	56.7%	76.5%	83.3%	91.7%	80%	93.8%

DPT2	56.7%	49.3%	74.5%	66.7%	77.8%	75%	93.8%
DPT3	30%	38.8%	72.5%	66.7%	63.9%	70%	81.3%
Measles	33.3%	46.3%	68.6%	58.3%	58.3%	75%	75%
Immunization Complete	23.3%	34.3%	66.7%	50%	55.6%	70%	71.9%
Immunization Complete before 1 year of age	16.7%	23.9%	45.1%	25%	44.4%	40%	62.5%
OPV drop out rate	47%	35%	5.12%	25%	30.3%	12.5%	13.3%
DPT drop out rate	47%	31.57%	5.12%	20%	30.3%	12.5%	13.3%

For Maternal 2TT, there are two HCs (Chung Cheag is 22.4% , Pon Lay is 32.5%) which exceed the first year of the project goal (15%), and the other five (Don Tey, Ta Am, Tropaing Pring, Dambai, and Tuk Chouv) are below the goal.

Health center	Woman's 2TT 15-49 years	Woman's 2TT before the birth of her child
Tuk Chouv	39.4%	6.1%
Dambai	37.2%	3.8%
Chung Cheag	62.1%	22.4%
Tropaing Pring	26.5%	0%
Ta Am	80%	10%
Pon Lay	65%	32.5%
Don Tey	71.1%	13.3%

Graph 3: Complete immunization before 1 year, and woman's 2TT before the birth of the child.



Implications for Health Field Staff

In the new area, among the 14 HFS there are 2 that did not meet the project expectations per LRA results for their training and supervision areas. In follow-up discussion with each of them, it was determined that they don't have enough time adequately supervise their care groups. The obstacle to performance was that the EPI out reach team do not yet go to all of the remote villages as they need to do. These HFS will do more mentoring with their CGLs to encourage the WHEs in their care group to follow through with home visits. The supervisor will also more closely supervise the HFS whose areas are underperforming to assist her more closely with problem solving.

In the old area, there are 4 HFS whose areas did not meet project expectations for women receiving at least 2 TT before the birth of their last child as verified by card. After discussion it was found that the women do not care for their immunization cards. She will be put more closely supervision and support from her supervisor to visit her care groups and she will encourage the care group to work as a team to review more with the women about any health lesson they learned before and how to take care of the immunization card.